

FILED OCT 24 1944
 1944

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K. C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day 2 hrs.
 In this community 1 day 2 hrs.
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Infant Parrish

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 1 1944
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 hr. min.

9. Birthplace Kansas City, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

MOTHER FATHER

12. Name Wm. Everett Parrish
 13. Birthplace Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Ethel Blankenship
 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address 20 S. Hospital

17. (a) Cremation (b) Date thereof Oct 4, 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 20 S. Hospital

18. (a) Signature of funeral director Wm. A. Johnson

(b) Address City, Missouri

19. (a) 10-4-44 (b) N. E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2325 Mercier
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17
 year 1944 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 16, 19 44 to May 17, 19 44
 that I last saw her alive on May 17, 19 44
 and that death occurred on the date and hour stated above.

Immediate cause of death Premature Duration _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
 Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of play)
 (c) Means of injury 0

23. Signature A. E. Upsher (M., D., or other) MD.
 Address Med. Dir. Gen'l Hosp. Date signed 5-17-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.